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THE BEST THINGS IN LIFE ARE FREE!
It's the shipping costs that are outrageous!

Do you remember the song from Porgy and Bess, "I Got Plenty of Nothin'?" In it, Porgy claims that he has everything he wants as long as he has the love of Bess. But then, the story goes on; he loses his Bess and has to undergo terrible hardships to regain her. Sound familiar and applicable to our lives? In order for any of us to have the life we want and the material things we want, it is often necessary to suffer a little: long hours, frustration, failures. But when you achieve that good feeling of satisfaction and contentment, you usually will say, "It was worth it!"

Dr. Knopf is editor of Harry's Homilies. © He is an ophthalmologist retired from private practice and a part-time clinical professor at Washington University School of Medicine.

SCAM-Q*
* How insurance companies, hospitals, government, etc.
Slice Costs And Maintain Quality

“We Know That the Health-Care System is Broken”
By Richard J. Gimpelson, MD

Read the headline of this column carefully. Do you really believe this? Well, some people do. Most likely some institutions also believe this. How do I know this to be the case? In West Newsmagazine, May 5, 2010, page 14, Denny DeNarvaez, Mercy’s regional president at the time, has this quote attributed to her. (Editor’s note: In June Ms. DeNarvaez became CEO of Wellmont Health System, a multi-hospital group based in Tennessee.) For your information, Mercy is the eighth-largest Catholic health care system in the United States with 30 hospitals and more than 1,300 integrated physicians in its system. The only recommendations in the article were “kids need better control of their eating and exercising, and we adults need better control of our weight.”

Now, I ask you what the above recommendations have to do with our healthcare system? Nothing in the article mentions anything about tort reform or access to or cost of medical care. There was a reference to a Harvard professor who predicted that due to poor eating habits and lack of exercise, current youngsters will not live to be as old as their parents will.

I am on the non-integrated medical staff of St. John’s Mercy Medical Center (maybe they will not want me after this article), and my recommendation for Mercy is to get rid of their entire medical staff (integrated and non-integrated) and convert all their hospitals to boarding schools where proper eating and exercise are drilled into each and every child who is enrolled. Mercy should also make sure that their schools are accessible to every child regardless of economic situations, so that someone does not start claiming that the nutritional and exercise system of the United States is broken.

There is nothing wrong with the quality of health care in the United States. Every Mercy physician delivers high quality health care. The problem is accessibility, the huge financial waste from medical-legal issues and high costs of health care. Nutrition and exercise are very important for enhancing good health, but they have nothing to do with the quality of health care in the United States or the health-care system.

After writing this column, I am going to start using my treadmill every day, quit eating doughnuts, and lose 40 to 50 pounds. I do not want to be a party to the broken health-care system in the United States.

Dr. Gimpelson, a past president of SLMMS, is a gynecologist in private practice.
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As numbers grow, supporters cite results in patient safety, coordination and cost savings

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Editor’s Note
SLMM has updated the date designations for our magazine issues. Starting with this issue, we are naming the issue by the month when it is distributed. Instead of July-August, this is the August-September issue. The publication schedule and number of issues have not changed.

The advertisements, articles, and “Letters” appearing in St. Louis Metropolitan Medicine, and the statements and opinions contained therein, are for the interest of its readers and do not represent the official position or endorsement of the St. Louis Metropolitan Medical Society. SLMM reserves the right to make the final decision on all content and advertisements.
What Is the Future of Private Medical Practice?

With the emergence of large hospital systems, the future of private medical practice becomes more uncertain. Doctors’ aptitude and determination has been tested in today’s economy and some have found these times too difficult to remain in their practices. Thus, the traditional view of the medical field has changed and the original appeal of private practice has been lessening day by day. With the complexity of managerial issues in regard to insurance fees, outstanding claims and responding to denials and medical note requests, as well as electronic health records and computerized systems, many private practice doctors are closing their doors and becoming employees rather than employers.

Furthermore, the cost of medical education has driven numerous young doctors out of buying into a practice. At the same time, quality of life is becoming increasingly important to these young doctors. They are not willing to spend long hours on clinical and business issues. With the opportunity of not having to deal with the complexity of owning and running a business, doctors are able to concentrate more time on patient care.

The debate is ongoing and the answers are still unknown but the decrease of private practice is a reality. However, I am sure there will always be doctors who enjoy the autonomy of owning and running their own practice. With this control, they are able to set their own hours and decide how things can and should be run. In turn, hospitals must learn to create an environment that is appealing to physicians, which includes accepting more input from doctors. As a result, hospitals will be able to attract a growing number of physicians, especially large group practices. Today, in our local metropolitan area, we have seen a trend of hospitals recruiting or at least talking to large groups of physicians to join their organization as employees.

Another phenomenon is the increased number of hospitalists or the private practice of hospital medicine. This is an attractive feature for solo practitioners who abandon their private practice and join one of the hospitalist groups.

As an internist in a small practice of just two doctors, am I an endangered species? Perhaps not. With the growing shortage of physicians, the services of small private practices definitely are still needed. In a state such as Missouri, many patients still prefer to see a single physician whether it be in the office, hospital, or nursing home. This enables the stability of care as well as allows patients to build a relationship of trust with their physician which is vital to their care. With the changes in health care and multiple players, is this all too idealistic?

The future of private medical practice is an issue of concern to all physicians.
Collateral Damage

Negative reaction to AMA support of health-care reform legislation sets of membership losses

Medical Society Executive Vice President Thomas A. Watters, CAE

This is the time of year when most membership organizations are counting heads and seeing how their membership numbers are doing as they begin to approach the end of the fiscal year. In the same way that we count our money and compare it to budget, we count members and see how that number compares to the goals we set at the beginning of the year. Often these two comparisons are inseparable, as our membership numbers strongly affect our financial statements.

This year we had a new challenge in what were already challenging times. The last couple of years have seen our membership numbers affected by a poor economy. Physicians have felt a financial pinch in their practices, and have been looking for ways to improve the bottom line. Unfortunately, some see their support of organized medicine as a place to trim a few dollars. However, this year we were faced with a significant and unexpected new obstacle – a giant snowball that began its roll downhill from meeting rooms in Chicago and Washington, D.C., and continued its trajectory through the state associations, and deep into organized medicine’s very core at the local society level.

When the AMA expressed its support for the new health-care reform legislation, it set off a roil in organized medicine that has’t been seen in a long time – perhaps never. No doubt there were, and are, many members who supported the AMA position. But there’s even less doubt that there were many who objected to the position, and demonstrated it by NOT writing their check to the AMA for their annual dues. Taking a controversial stance on such a divided issue may or may not have been the right thing to do – there are logical arguments on both sides of the debate. But I question whether the AMA leadership had any idea how serious the membership’s reaction would be.

Membership figures from the AMA have been a little hard to come by, but I have it on good authority that they are down about 15% this year. I’ll be surprised if it’s not more when the final numbers are revealed. (Just my opinion, but that’s why this is called an editorial!) They took their position and paid the piper. I’m not criticizing them, but merely relating the situation because of its impact on SLMMS.

Many physicians are jointly billed for their AMA dues, their state association dues and their local component society dues (SLMMS) on one invoice. Usually there are advantages to doing it this way, but not when one of the associations gets themselves into a bind the way the AMA has. Many physicians were angered with the AMA, and that anger spilled over to the state associations and the local societies which had nothing to do with the AMA decision on health-care reform. In fact, MSMA actually took an opposing position. SLMMS, trying to remain positive and stay above the fray, issued statements, letters and press releases saying what pieces of health-care reform they did support.

Right or wrong, the damage done to membership rosters around the country by the AMA position is evident. Because of the initial joint billing, and the propensity of some members to chuck the entire bill into the trash, both MSMA and SLMMS suffered serious collateral damage. The MSMA then made a decision after this first round of billing to discontinue billing for AMA dues, and succeeding invoices only requested payment of MSMA and SLMMS dues. This helped significantly.

Still, our list of non-renewing members is higher than it has been in years. However, there are a lot of positive signs and we have already overcome a good part of the deficit.

SLMMS made a special effort to let its members know that we are NOT the AMA. Personally, I had a number of calls requesting assurance that money paid to SLMMS would not go to the AMA. We were able to convince most of our members that this was not only a bad time to desert their local society, but it was the worst possible time. With the lack of support for and depressed national standing of the AMA, there has never been a more important time to support state and local organized medicine. Where else is your voice really being heard?

Some of those reading this magazine may be on our “non-paid members” list still. If so, I urge you to reconsider the importance of your membership.

With the lack of support for and depressed national standing of the AMA, there has never been a more important time to support state and local organized medicine.
Now, the good news. Our president this year, Sam Hawatmeh, MD, made it clear from the time he was elected that his primary goal as president would be to increase our membership. His personal goal was 100 new members and it looks like he will achieve that goal. And, I don’t expect him to stop there. Because of a strong effort on his part, we have been able to significantly offset the negative effects of a continuing weak economy and the spill-over from the AMA debacle. We have also been helped by the continuing membership campaigns of the MSMA which bring us new members as well.

This year we have already added 97 new members, and, we have five months to go. That is a significant number, and if it weren’t for higher than usual losses, I’d say we were having a great year in membership. However, we’ve been working hard – writing, calling – on our list of non-paid members. We’ve had 44 members tell us unequivocally to drop them, and we still have about another 110 who will soon be dropped if we don’t hear from them. So, in spite of a lot of hard work and a great year in adding new members, we will soon be in the red again. But then, we still have those five months remaining.

We could use your help. If you have a friend or colleague who is not a member, urge him or her to join. It’s as simple as asking them to go to our website (www.slmms.org). If you happen to be one of those members who has not renewed for 2010, please do so. And most importantly, if you’re a paid-up member, remain so. We need you, and you need us, more than ever.

■ ■ ■
Physicians and hospitals need each other – it is truly a symbiotic relationship. However, is it ever advisable for a physician to leave private practice to enter an employment relationship with a hospital? To help answer that question, this article will explore three areas of core differences between hospitals and medical practices. They are: 1) goal incongruency, 2) operational and cultural environments, and 3) payment mechanisms. Additionally, a listing of 22 questions will be offered to assist physicians who are contemplating employment within a hospital organization.

Admittedly, this is not a scientific paper based on research or survey data. It is more of a commentary based on empirical and experiential evidence. Nevertheless, it may be somewhat instructive in any consideration of becoming (or being) an employed physician.

Goal Incongruency

Experience suggests that many hospital/physician conflicts stem from incongruent goals. In some cases, goals can actually be mutually exclusive. It continues to be a challenge to resolve this basic conflict.

For example, it is widely reported that hospitals, on average, have operating margins of only about 2%. This places tremendous pressure on hospital administrators to carefully manage expenses and operate efficiently. There are many techniques to do so, but perhaps most common is the use of “standardization.” Standardization enables structure, predictability, economies of scale and other valuable, cost containment results. It also provides consistent rules and etiquette to be observed by hundreds, or perhaps thousands, of employees. Economically speaking, inventory control for two brands of sutures is more efficient than six. Purchasing and stocking one generic drug and one brand name drug is better than seven brand name drugs. Scheduling and staffing operating rooms for maximum efficiency is better than doing so for each surgeon’s personal time availability. And so forth. Furthermore, from a quality perspective, there are many aspects of hospital patient care that lend themselves well to standardized practices.

From the physicians’ viewpoint, service customization, not standardization, may be preferred. Physicians and patients have individualized needs. An internist’s experience might suggest that, in some cases, a specific drug brand is superior to other brands typically maintained in a hospital’s inventories. A surgeon’s time may be more productive if two or three operating rooms are available simultaneously to him or her. More nursing staff to attend patients’ subjective needs might yield greater patient (and family) satisfaction, thus resulting in fewer complaints to their physicians. Consequently, physician preferences may require resources that are less efficient and more costly than what the hospital’s standard fare allows. Additionally, hospital administrators and all members of the medical staff may not agree that standardized practices yield better quality, service and cost outcomes.

There will always be some degree of give and take between “standardize” versus “customize” practices; yet, it is desirous for hospital administrators and physicians to work together to resolve their differences, to identify best practices and, ultimately, to collaborate and achieve the best results for everyone’s benefit. To do so requires a good understanding of, and positive attitude and respect for, the other party and its needs. Accordingly, it is wise to choose partners carefully.

Operational and Cultural Tendencies

Most reasonable people would agree that a hospital’s operational and cultural environment is dramatically different than that of an independent medical practice. When comparing these environments, it is apparent why they are, and perhaps must be, different. Table 1 illustrates examples of this great contrast.

One might further describe these environments as follows: hospitals are generally “corporate” and medical practices are generally “entrepreneurial.” Neither term is intended to be pejorative. Both have positive and negative attributes.

Hospital administrators occasionally encounter situations when physicians do not understand, or at least cannot tolerate, the hospital’s sometimes rigid, decision-making bureaucracy. Standardized operations require structured policies and procedures in order to minimize risk, control costs and optimize quality. Stepping outside of these structures can be contrary to a hospital’s fi-
nancial goals or risk management strategies, and in some cases can lead to very costly results. Consequently, hospital administrators are not inclined to make exceptions for physicians, thus giving the appearance of being indifferent, obstructive or acting contrary to physicians’ best interests. Of course, this is a much different environment than that of a medical practice.

No doubt, hospital bureaucracy sometimes gets in the way of efficient and sensible solutions, thus frustrating the medical staff. It is also true that physicians sometimes over-simplify complex issues that, without the benefit of a thoughtful approach, can result in undesirable consequences for hospital administrators. Understanding and tolerating each others’ environments can be helpful in attempts to forge better relationships, especially within an employment model. It just isn’t always easy to do so.

Payment Mechanisms

Hospitals and physicians have different revenue components. Hospitals operate in a world of DRGs, RUGs, DSH payments and other facility-oriented payment mechanisms. Physician compensation is determined by RVUs, RAF scores, capitation payments or other factors. Table 2 lists examples of payment components used in hospital and physician reimbursement mechanisms.

Both reimbursement worlds are complex, sometimes overlapping and sometimes apart. It is not possible in this brief article to sufficiently describe each of these components and their inherent implications. Nevertheless, experience suggests that many hospital administrators do not truly understand medical practice payment components, and many physicians do not truly understand hospital payment components. Accordingly, it would be helpful for hospital administrators and physicians to continuously educate one another on their respective reimbursement mechanisms. It could lead to greater insight as to how one might better help the other.

Twenty-Two Questions for Physicians Considering Employment

Given the contrasts between hospitals and medical practices, physicians considering employment opportunities within a hospital or with a hospital-sponsored medical group might find it helpful to first make an honest assessment of the institution. The following 22 questions are intended to aid such an assessment.

1. What do I want from hospital-sponsored employment (e.g., income guarantee, fewer administrative responsibilities, better technology, access to more affordable health insurance coverage, strategic advantage, etc.)? It is helpful to make a list, carefully evaluate each entry and clearly define the primary reasons for seeking employment. Prioritize the

Table 1. Examples of Contrasting Operational and Cultural Environments

<table>
<thead>
<tr>
<th>Environmental Components</th>
<th>Hospital</th>
<th>Medical Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance</td>
<td>Board of Community Volunteers</td>
<td>Owner(s)/Partners</td>
</tr>
<tr>
<td>Administration</td>
<td>Senior Managers with Advanced Degrees</td>
<td>Practice Manager, Degree Optional</td>
</tr>
<tr>
<td>Sources of Revenue</td>
<td>Diversified Across Multiple Services</td>
<td>Mostly Professional Fees</td>
</tr>
<tr>
<td>Decision Making Process</td>
<td>Group Oriented, Analytical</td>
<td>Self Oriented, Instinctive</td>
</tr>
<tr>
<td>Approval Processes</td>
<td>Structured &amp; Elongated</td>
<td>Informal &amp; Rapid</td>
</tr>
<tr>
<td>Sources of Capital</td>
<td>Multiple</td>
<td>Few</td>
</tr>
<tr>
<td>Purchasing</td>
<td>Large Buying Consortiums</td>
<td>Local Suppliers and Retailers</td>
</tr>
<tr>
<td>Written Policies and Procedures</td>
<td>Comprehensive</td>
<td>Minimal but Adequate</td>
</tr>
<tr>
<td>Accounting and Finance</td>
<td>Sophisticated</td>
<td>Simplified</td>
</tr>
<tr>
<td>Technology and Support</td>
<td>Extensive</td>
<td>Limited</td>
</tr>
<tr>
<td>Income Tax</td>
<td>Exempt, Pay Nothing*</td>
<td>Earn More, Pay More</td>
</tr>
<tr>
<td>Operating Margin</td>
<td>2%</td>
<td>50% (Before Physician Earnings)</td>
</tr>
<tr>
<td>Magnitude of Liability Risk</td>
<td>$50,000,000</td>
<td>$1,000,000</td>
</tr>
</tbody>
</table>

* Non-profit hospitals only.

Table 2. Examples of Reimbursement Components and Methodologies

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>Medical Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Related Groups (DRGs)</td>
<td>Relative Value Units (RVUs)</td>
</tr>
<tr>
<td>Resource Utilizations Groups (RUGs)</td>
<td>Geographic Practice Cost Index (GPCI)</td>
</tr>
<tr>
<td>Ambulatory Payment Classifications (APCs)</td>
<td>Conversion Factors (CF)</td>
</tr>
<tr>
<td>Per Diems</td>
<td>Capitation</td>
</tr>
<tr>
<td>Disproportionate Share (DSH) Payments</td>
<td>Physician Quality Reporting Initiative (PQRI)</td>
</tr>
<tr>
<td>Surgical and Global Case Rates</td>
<td>Risk Pooling</td>
</tr>
<tr>
<td>Average Wholesale Price (AWP)</td>
<td>Gain Sharing</td>
</tr>
</tbody>
</table>
Where Do I Go From Here?
The Private Practice Physician’s Dilemma

By Jerrie K. Weith, FHFMA

The days of Marcus Welby-era medicine are a distant memory. Today’s physicians are responding to an incredible amount of change. Some doctors are reacting passively with an “I’ll wait and see what’s going to happen” attitude. Others are reacting with a more proactive “Let’s evaluate some options and be prepared” stance. This article will illustrate some of the alternatives for St. Louis-area physicians that will dictate the practice of medicine for years to come.

What are the options?

There are several options for practice structure, management and financial viability available to physicians. Unfortunately, there is no single solution that fits everyone – that would be too easy! The good news is that there are options available to meet each doctor’s needs. While there are many options, here are some of the more common:

1. Stay entirely independent.
2. Merge with other medical group(s).
3. Contract yourself and/or components of your practice with a hospital/health system (collectively referred to as hospital in this article).
4. Become an employee of a hospital/health system.

Stay Entirely Independent: This statement says it all. If you’ve selected this option, you’ve decided your independence is worth potential risks in the marketplace, including risks of lower compensation or “crowding out” by larger groups/hospitals. When would you consider this? Perhaps if you’re nearing retirement or if you aren’t nearing retirement but rely very little on hospital interactions. An example is an internist who assigns inpatient care to the hospitalists after hours.

Merge With Other Medical Group(s): In this scenario, you’ve made the decision that remaining on your own isn’t financially feasible, but you aren’t comfortable with being an employee. Merging with one or more medical groups of similar size helps to form a “mega” group, depending on the number of physicians. There are significant advantages to joining with other groups including marketplace power, influence with payers, buying power, and economies of scale. Major disadvantages include a loss of autonomy and the culture change from “my practice” to “our practice.”

Contract Yourself and/or Components of Your Practice: This concept is generally referred to in current literature as a Purchased Service Agreement (PSA). With a PSA, the doctor enters into a lease arrangement with a hospital to provide a specific scope of professional services. In return, the practice is paid a negotiated value for providing those services. The arrangement can be as limited as the physician services of the group or as broad as leasing all the functions of the practice, including facilities. There is no sale of assets in this transaction. Most experts view this arrangement as an alternative to selling the practice to the hospital and entering into an employment arrangement.

Become an Employee: This alternative provides the least autonomy of the four. It’s pretty straightforward – the doctor discontinues practicing as an independent doctor and joins the employed medical staff of the hospital. (The physician could also be employed by another group, as well.) This scenario may or may not include an actual purchase of the practice by the new employer.

The same cautions under a PSA arrangement are reinforced here. Don’t be tempted to go into employment thinking if it doesn’t work out, you can always go back to your private practice. The health-care landscape will have changed during that period of employment and you aren’t assured what type of economic conditions we will be experiencing.

How do you evaluate the options?

There is a right and wrong answer as to which option is best in
What’s right for Dr. Jones may be the opposite of what is right for Dr. Smith. It takes quite a bit of soul-searching to know what’s right for you and your practice. Here are some concepts and questions to consider while you’re making the decision:

- **Culture** – Whenever a physician has regretted a decision to change from private practice to something else, the usual reason has been the “culture shock.” The importance of an environment’s culture should not be downplayed. If Dr. Smith enjoys a laid-back and staff-friendly environment and joins a regimented style of practice, he’ll be miserable and so will his staff! It won’t take the patients long to feel the tension either.

- **Financial** – Consider all of the financial aspects. Think about the new compensation structure, economic advantages of the new group, allocation of expenses and overhead. Try to think past the sale price of your practice if you’re considering selling and staying in practice; also think about the ongoing financial implications.

- **Independence** – Doctors who excel in private practice are entrepreneurial by nature. They’re used to making business decisions and living with them. If your personality is one that enjoys analyzing the opportunity, making a decision, and moving on, then some of the four options won’t fit you very well.

- **Time Frame** – Determine when this decision works best for you. If you are interested in options 2-4, pursue that option so you allow yourself the most opportune entry point into the discussion. For example, if you’re a cardiologist and interested in joining the biggest medical group in town, don’t wait until that group has already brought on five other cardiologists before making your move. Once you’re in the negotiation, don’t hurry it nor drag it along. There will be a pace to the negotiations that should feel comfortable.

- **Reputation** – You have devoted your practice to quality medical care and ethical business decisions. Be sure that your future business “partners” are as dedicated to these concepts as you are.

- **Fear** – The health-care industry is scary right now. Who knows how we’ll get paid, when, and by whom. But avoid making decisions about your and your practice’s future out of fear. Good business decisions are not made from fear, but rather from analyzing the data and executing decisions based on that analysis.

- **Help** – Ask for help from others who have been involved in these decisions. You might check with colleagues who have made the choice you’re considering. Ask them if they would do it again, what went well and what didn’t. Consult with your practice advisors such as attorneys, accountants and consultants. They can draw on experiences with similar clients.

Yes, the practice of medicine has surely changed. We can lament the impact of past changes, but we will be better positioned if we look forward to the changes as they are developing in front of us. Now is the time to decide which of the four options in this article fits you best and then develop an action plan to position yourself in the best place possible.

Jerrie Weith is Director of Health Care Services with Anders Minkler &Diehl LLP. Jerrie’s health-care team specializes in physician practice success, including analysis and implementation of integration models. You can contact Jerrie at (314) 655-5558 or jweith@amdcpa.com.
Hospitalist Medicine Increases Impact

As numbers grow, supporters cite results in patient safety, coordination and cost savings

A growing number of hospitalist physicians are working in the St. Louis area and nationally. Hospitalist medicine calls itself the fastest-growing medical specialty.

Nationally, more than 30,000 hospitalists are practicing in more than 3,300 hospitals, including 80 percent of hospitals with over 200 beds, according to the Society of Hospital Medicine. Most hospitals in the St. Louis area employ hospitalists to some degree.

Supporters of hospitalist medicine say it improves patient safety, reduces length of stay and improves coordination among the health-care team. Others express concern that hospitalist medicine lessens the role of the traditional primary-care physician. This St. Louis Metropolitan Medicine feature includes commentary offering these various perspectives.

Background

The hospital medicine movement was spawned in the United States in the early 1990s out of growing concerns about patient safety and rising costs, increasing demands on primary care physicians to spend more time at their offices, and the lack of any single hospital-based provider to coordinate the entire care of a hospitalized patient, according to the Society of Hospital Medicine.

The term “hospitalist” was first used in a 1996 New England Journal of Medicine article by two physicians at the University of California, San Francisco, Department of Medicine, Robert Wachter, MD, associate department chair, and Lee Goldman, MD, department chair and editor of the American Journal of Medicine.

The SHM says hospital medicine is a medical specialty dedicated to the delivery of comprehensive medical care to hospitalized patients. Practitioners engage in clinical care, teaching, research and leadership related to hospital care. They help manage patients through the continuum of hospital care, often seeing patients in the ER, following them into the critical care unit and organizing post-acute care. Patients also may be referred to the hospitalist by their primary-care physician or a specialist.

In October 2006, the American Board of Internal Medicine announced plans to recognize hospital medicine as a distinct field of internal medicine.

About 82 percent of practicing hospitalists are trained in general internal medicine, while 6.5 percent are trained in general pediatrics, and another 3-4 percent each in an internal medicine subspecialty, family medicine and internal medicine pediatrics.

Locally, hospitalists typically are employed by the hospital or by one of several companies that provide staffing for hospitals. St. John’s Mercy Medical Center employs 37 hospitalists for adult patients and 14 for pediatric patients; St. Luke’s Hospital employs eight full-time hospitalists.

One of the largest staffing companies is IPC The Hospitalist Company which employs 65 practicing hospitalists and physician extenders working in the St. Louis metropolitan area. Their physicians manage over 700 patients per day in 14 different hospitals, including various SSM hospitals such as DePaul, St. Mary’s, St. Clare and St. Joseph, as well as the BJC HealthCare’s Barnes-Jewish St. Peters, Christian and Progress West HealthCare Center hospitals. St. Anthony’s Medical Center utilizes several staffing companies including IPC for its 15-20 hospitalists.
Quality of Care Improves With Use of Hospitalists

Editor’s Note: Following are responses from Philip Vaidyan, MD, FACP, practice group leader for hospitalists at SSM St. Mary’s Health Center. He and his group are employed by IPC The Hospitalist Company.

What are the benefits and advantages of hospitalists to the practice of medical care?

Dr. Vaidyan: Patients benefit from having a hospitalist manage their care in the hospital in many ways. First, you have a physician in charge of all aspects of their care while in the hospital. The hospitalist is available all day long to manage any issues that arise during the patient’s hospitalization. They also become experts in the hospital systems and are therefore able to bring the physician’s perspective to designing systems which will provide an efficient and high-quality hospital experience for the patient.

Many studies show that the quality of care improves with use of hospitalists. The Modern Healthcare list of Top 100 hospitals had one consistent theme when looking at why a hospital made the Top 100 list. All of the hospitals had a hospitalist program. Many other studies show that core measure compliance increases and quality metrics are improved.

What is the response from primary care physicians?

Dr. Vaidyan: Primary care physicians are very supportive of hospitalists. The demands of managing a patient’s experience in the hospital are growing more and more intense. This places a significant burden on a primary care physician who has a busy office practice to manage. The primary care physicians who utilize hospitalists constantly tell us that they are able to spend more time managing their office practice and their practice income actually increases. This is because they are able to be more productive in their office and not have the unproductive time associated with going to and from the hospital and interruptions in their office day due to demands of managing their inpatients.

Does this provide better care to the patient? If so, how?

Dr. Vaidyan: All patients benefit from having a hospitalist manage their care. Patients with many co-morbid conditions and medical issues see significant benefit because the hospitalist acts as the quarterback on the case. While the specialists are managing their specific area of expertise, the hospitalist is able to manage the entire patient’s care and bring it all together for the patient. In many hospitalizations, as many as 100 different caregivers may come into contact directly or indirectly with the patient. The hospitalist is the clinician in charge of all these caregivers and who directs the overall care. Hospitalists are now also managing or co-managing many surgical cases. The surgeons utilize the hospitalist for pre-surgical or post-surgical care, or both. Many of the post surgical issues require ongoing medical management, and hospitalists are uniquely qualified for this.

(continued on next page)
Hospitalist Medicine Increases Impact
(continued from page 17)

Do patients have shorter lengths of stay and lower costs when cared for by a hospitalist? If so, why?

**Dr. Vaidyan:** Frequently, patients managed by hospitalists have a lower length of stay and lower costs. There are several reasons for this. One is that because hospitalists are in the hospital all day, they are able to work closely with case management and social workers. They know what needs to be done to get things done quickly and efficiently. They are available to review test results throughout the day and make timely decisions based upon these results rather than wait until the following day. Hospitalists are also aware of the many post-acute care options available for patients, including home care, nursing home, acute rehab, long-term acute care, etc. IPC hospitalists manage patients in many of these sub-acute settings providing for even more consistency and continuity of care. Hospitalists also are able to work with the hospital to manage costs and utilization of services. They actively participate in various committee structures and provide valuable clinical insight into the management of the hospital.

Hospitalists Do Not Lower Hospital Costs

*By Arthur Gale, MD*

According to a 1998 American Medical Association report, the hospitalist model was first introduced at Kaiser Permanente hospitals, the Park Nicollet Clinic in Minnesota, and CIGNA HealthCare of Baltimore Maryland in the mid 1990s. All of these organizations were strong advocates of managed care.

The intent of the hospitalist movement was to decrease hospital utilization and costs without jeopardizing quality of care and patient satisfaction. Initial studies of the hospitalist model were favorable. However, these studies were limited in scope and were largely observational.

In 2007 the first large study comparing the effect of internists, family physicians and hospitalists on lowering hospital costs was published in the *New England Journal of Medicine*. There were 77,000 patients in this study. It showed that the hospitalist model had little or no effect in lowering hospital costs.

The study’s conclusions were:

“For common inpatient diagnoses, the hospitalist model is associated with a small reduction in length of stay without an adverse effect on rates of death or readmission. Hospitalist care appears to be modestly less expensive than that provided by general internists, but it offers no significant savings as compared with the care provided by family physicians.”

A 2007 AMA report offers some interesting insights and facts on the hospitalist movement:

- Hospitalists are the fastest growing specialty in medicine. There were 15,000 hospitalists in 2007 up from 1,500 ten years earlier. The number of hospitalists is expected to grow to 30,000 in the near future. Hospitalists are present in 70% of U.S. hospitals where they care for over two-thirds of hospitalized patients.
- About 64% of hospitalists are subsidized with a median subsidy of $60,000 per year. (This means that hospitalists’ income is not solely dependent on third-party reimbursement as is the case with most U.S. physicians.)
- The median total compensation package of hospitalists was $168,000.
- There is a high turnover rate among hospitalists. It appears that the greatest weakness of the hospitalist model is burnout.

The AMA report notes that there are six hospital employment models. An example of a publicly owned for-profit employment model that has a significant presence in St. Louis is IPC The Hospitalist Company. Key financial numbers for the fiscal year ending December 2009 were: sales $310.5 million; one-year growth 23.6%; net income $18.6 million.

In my view the rise of the hospitalist movement has contributed to the collapse of primary care. As more internists and family physicians become hospitalists fewer enter primary care. The likely reason is that the pay is better and there may be less hassle. Managed care created the hospitalist movement with the primary goal of lowering hospital costs. The *New England Journal of Medicine* study has clearly demonstrated that this goal was not achieved. Like most other managed care strategies to lower health care costs, it has been a failure. But, despite its ineffectiveness, as long as managed care is in the driver’s seat in setting health care policy, the hospitalist movement is here to stay.

*Dr. Gale is a past president of SLMMS and frequent contributor to this magazine.*
Hospitalists Fill a Void

By Lawrence O’Neal, MD

In medicine, as in the mercantile world, what is paid for is what is supplied. The third-party payment policies have reshaped physician demographics. Procedures and tests are finite and identifiable and are paid. The value of advice and counseling is not so easily determined. Though levels of care in office visits to internists are roughly defined, payment to them has become basically for time. The internist is paid the same for an office visit when an MRI is recommended, as when it is decided that the patient doesn’t need an MRI. The cognitive services, once so valued, are now discounted.

One result of the payment policies has been the rupture of continuity of care. Hospital rounds for many internists have become un.rewarding. In a study last year in *NEJM*, only 30 percent of the patients in hospital were seen by a physician who had attended them during the previous year. Don’t expect any more that your doctor will see you in the hospital, let alone skilled nursing units or nursing homes. The recent sub-specialty of hospitalists not only fills a void but a need. Competent physicians are on site to offer efficient management and response to changes in course.

The recent health-care legislation attempts to revive the incentives for general internists to practice, but have come too little, too late.

Dr. O’Neal is a past president of SLMMS and retired chief of surgery at St. John’s Mercy Medical Center.

For More Information

Websites

Society of Hospital Medicine
www.hospitalmedicine.org

IPC The Hospitalist Company
www.hospitalist.com

Journal Articles

“Hospitalists and the Quality of Care in Hospitals,” *Archives of Internal Medicine*, August 10, 2009.


most important entries and ask yourself if employment will get you what you want.

2. Why does the hospital want to employ me?
3. Do I have a trusting relationship with a high-ranking hospital administrator who will advocate for me, my practice and my ideas, and who will guide me through the hospital’s corporate processes?
4. Can I prepare myself mentally to accept the probability that approval processes will take longer than I am accustomed and not always result in my desired outcome?
5. Does the administrative team understand my concerns and needs and will they help me address those concerns and needs?
6. As an employee, how much autonomy and decision-making authority do I require for contentment and will those levels consistently be granted to me?
7. What will be my accountability to a budget, if any, and who will prepare that budget?
8. Will my employment place me in the company (and the collective identity and reputation) of professionals whom I respect?
9. Do I truly understand how I currently get compensated and how that might change in the employment model?
10. How will my medical practice be managed, and by whom?
11. How will my office staff be selected, evaluated, hired or fired?
12. What policies, procedures, accreditation requirements or other formalized standards will I be expected to observe?
13. Who will have long-term custodianship of my patient records?
14. Is my prospective employer financially stable and capable of honoring my employment contract for its duration?
15. Do I clearly understand the implications of any restrictions or covenants that I must honor during and after my term of employment?
16. What technology, both hardware and software, will I be expected to use and how will it impact me and my practice?
17. Is there a well-defined mechanism for resolving disputes?
18. What are the barriers or penalties for leaving employment if I later find I do not like it?
19. Have I received appropriate legal and tax advice for the proposed employment arrangement?
20. Do I have a strategy to return to private practice, or other alternative, should the employment arrangement come to an end?
21. If my patient base is too small or too large, will the hospital help me address it?
22. Do I have enough information regarding how health-care reform legislation might impact my practice, employed or not?

Physicians who are able to arrive at honest and accurate answers to these questions are to be commended. It is a difficult exercise, but then again it should be given the importance of the decision at hand.

Parting Comments from the Author

From time to time, a physician will ask my opinion about an employment opportunity. My usual response is, “it depends.” It depends on what a physician is seeking. I believe that question number one from the above list is the most important question. If hospital-sponsored employment satisfies a physician’s most important needs, then it most definitely is worth consideration.

Unfortunately, I am aware of too many physicians who are not happy in their hospital-sponsored employment arrangements. In many cases, they did not have a clear understanding of what they were seeking. Some had unreasonable expectations. Others did not consider the operational and cultural environments they were entering. Some have expressed regret for agreeing to “exit barriers” that make it very difficult to leave employment. A few confessed they hastily entered into employment agreements because their practices were in trouble and they didn’t know what else to do. Be careful not to make those same mistakes.

It is possible to find suitable employment in a hospital organization, but it is unlikely one will get everything wanted in an employment arrangement. Compromises will have to be made, and personal expectations will have to be realistic.

I have supported physicians in starting practices, building practices, closing practices, selling practices, merging practices, entering hospital employment and leaving hospital employment. Each situation had its own unique circumstances. Yet, there was one common thread in all situations: change. Each of these physicians determined it was necessary to undergo change in order to get to the next stage of their professional careers. If you are considering making a change by entering hospital-sponsored employment, I recommend you first carefully consider the contrasting operational and cultural environments and then answer the 22 questions. Whatever choice you make, I wish you all the best.

Steven R. Stout is co-owner and partner at KASS-MSO, Inc., a St. Louis-based firm specializing in administrative support for medical practices. Previously, he served as an executive at Deaconess Incarnate Word Health System and Tenet St. Louis. Responses to this article are welcomed. Mr. Stout may be contacted at (636) 225-5445 or through www.webkass.com.
Alliance Officers for 2010-11 Announced

President
Angela Zylka

Vice President-
Membership
Janice Singer

Vice President-Health
Sandra Murdock

Vice President-
Legislation
Sue Ann Greco

Vice President-
AMA Foundation
Gill Waltman

Treasurer
Kelly O’Leary

Recording Secretary
Millie Bever

Corresponding Secretary
Jean Raybuck

AMA Alliance Adopts Bylaws Changes
By Sandra Murdock

The AMA Alliance held its annual meeting in conjunction with the AMA annual meeting June 11-15 in Chicago.

Missouri delegates to the AMA Alliance were Allene Wright, Michele Kennett, Mary Shuman, Anne Turnbaugh, Jackie Remis and Barbara Hover. Sandra Murdock served as a delegate from the National Medical Association Alliance. Mary Shuman of St. Joseph was elected as AMA Alliance director for a three-year term.

Delegates passed three important bylaws changes:
• An AMA Alliance Regular Member is now defined as a spouse, widow or domestic partner of a physician who is a member of AMA. An Associate Member is defined as a spouse, widow, divorced spouse (not remarried) or the domestic partner of a physician not a member of AMA. This also applies to the spouse or domestic partner of resident physicians or medical students. This means that domestic partners are now accepted as members of the AMA Alliance when they pay dues.

• By a vote of 123-32, the AMA Alliance has instituted an annual meeting format allowing any eligible AMA Alliance member to become a voting member of the meeting upon registration. There will no longer be delegates elected from each state.

• To be eligible for AMAA president-elect or any office you no longer have to have served as a state president.

The AMA Alliance installed its 2010-2011 officers: Susan Todd of Texas as president; Emma Borders of Louisiana as president-elect; Sarah Sanders of Indiana as secretary and Pat Hyer of Texas as treasurer.

Also featured at the conference were educational workshops, award presentations, national headquarters report, and a presentation by Barbara Hannah Grufferman, nationally acclaimed author of The Best of Everything After 50.

The general AMA conference theme was Helping Doctors Help Patients. Cecil B. Wilson, MD, from Orlando was installed as the 165th AMA president.
Minutes of the SLMMS Council
(Abridged)

EDITOR’S NOTE: The following are provided in abridged form. For a copy of the full minutes, please contact Liz Webb at the SLMMS office, (314) 989-1014 or e-mail lizw@slmms.org.

May 11, 2010

Call to Order. The meeting was called to order by Dr. Sam Hawatmeh at 7:00 p.m. in the conference room at the West County Radiology Office.

Approval of Consent Agenda. The Consent Agenda consisted of April SLMMS Council and SLSMSE Trust minutes and the Membership Report with five new members. Dr. Michael Hatlelid moved to approve the Consent Agenda and the motion carried.

Spring CME Symposium. Dr. Elie Azrak gave an update on the CME conference, ‘Managing and Protecting Your Assets,’ that took place on Saturday, April 17. He said the 13 people who attended participated in a great seminar. He also said it might be time to readdress the tradition of having two CME programs on Saturday (one in the spring and one in the fall) because of the lack of attendance.

Greater St. Louis Science Fair Update. Drs. Donald Blum, Edward Burns, Beverly Kraemer and James Perschbacher represented the Medical Society in judging the Greater St. Louis Science Fair. Project in the Health, Medical and Biochemistry categories were judged for grades 6-12 plus Honors. Border’s gift cards were given to the top project in grades six through nine with checks given to grades ten through twelve.

Fall CME Program. Topics and details of the fall CME program were discussed at length. Dr. Michael Stadnyk thought people were reluctant to attend programs on the weekend. It was decided to schedule the fall CME program for Wednesday, November 17 at 7:00 p.m. in the hopes of increasing attendance. Dr. Elie Azrak was asked to serve as program chairman. The following topics were suggested: where is health-care reform going (needs to be realistic and practical); delivering accountable care for physicians and patients; EMR or e-prescribing; current operation regulations or requirements; medical homes; global fees and comparison of Canadian and European socialized medicine.

City Pseudoephedrine Bill Update. Mr. Tom Watters reported that the bill proposed concerning banning pseudoephedrines did not get out of committee for the last session of the St. Louis Board of Aldermen. The bill may be re-introduced during this session. If that happens, a letter will be written and testimony will be given at the committee meeting in opposition to the bill.

Date & Location of 2011 Installation. The installation banquet will be Saturday, January 15, 2011, at the Hilton St. Louis Frontenac Hotel.

Report of Finance & Endowment Committee Meeting. Treasurer David Pohl reported on the meeting with the auditors from Conner Ash. They have expressed an unqualified opinion on our report and find that our statements represent fairly the financial conditions of SLMMS and SLSMSE. The Council asked that they be provided copies of the audit electronically after the meeting so it could be reviewed in more detail, and a vote for acceptance will take place at the next meeting.

One area of concern expressed by the auditors was the low proportion of the overall income for the foundation coming from contributions. Because we have a reasonably large investment portfolio, most of our income has been coming from investment earnings rather than contributions. Anytime the proportion of income from contributions drops below 33 percent, it can be a red flag for the IRS, and possibly expose us to an audit. There are a couple of ways to solve this problem, which the Council will address in the coming months.

Rare Book Collection Agreement Revision. Mr. Watters reported that the rare book collection agreement is being updated. He is working with an attorney from Armstrong Teasdale.

Form 990 Review. The Council reviewed the Form 990 in its entirety, and approved its filing.

Review of Dues. Mr. Watters reminded the Council that a small dues increase was enacted last year. A policy was also adopted requiring the Council to review the amounts of our dues each year. It was decided that a dues increase is not needed at this time.

Unpaid Members List. A list of 221 unpaid members was distributed. All Council members were asked to contact any unpaid members and encourage the members to maintain their membership in the Medical Society. Personal contact from a colleague during this tumultuous time might mean the difference in maintaining membership or dropping membership. Mr. Watters reported that other societies are down in membership numbers. MSMA’s membership numbers are down about 10 percent.

Metropolitan St. Louis Psychiatric Center Closing. Dr. Thomas Applewhite reported that severely mentally ill patients are being taken to Metropolitan Psychiatric Center (MPC) instead of the old Malcolm Bliss. Due to state cutbacks, the facility will be closing with no plans for the patients. Patients will be forced to go to other facilities not prepared to deal with the severity of mental illness (including those diagnosed as criminally mental ill) or the patients will just be on the street. A letter will be written to the governor and additional efforts will be made to contact the media regarding this closing.

Treasurer’s Report. Dr. Pohl gave the Treasurer’s report. The invoices for May totaled $15,771.48, with $3,080 transferred to MSMA for dues, leaving $12,691.48 in miscellaneous bills. Dr. Janet Ruzycki moved to approve the payment of the invoices. The motion carried. There were no SLSMSE invoices.

Utilization Review Resolution Update. Dr. Azrak reported his resolution on utilization review was referred to the MSMA Coun-
cil. He received a phone call from United Healthcare and they are anxious to cooperate on this issue. The MSMA Council has not yet taken up the resolution.

MSMA Consumer-Driven Medicine Committee Meeting. Dr. Stephen Slocum will chair an MSMA committee meeting at the Medical Society office. Also attending will be Mr. Pat Mills of MSMA, Drs. Elie Azrak, Ravi Johar and Laurence Levine along with Congressman Todd Akin, Debbie Cochran, his aide, and Julie Eckstein, Center for Healthcare Transformation. They will be discussing consumer-driven medicine.

BJC Learning Institute. Dr. Hawatmeh and Mr. Watters attended the BJC staff symposium on April 21 to distribute information and membership applications.

St. Louis Area Business Health Coalition Midwest Health Initiative (MHI). Dr. Collins Corder gave an update on the Midwest Health Initiative (MHI). On June 11, letters will be sent to primary care physicians explaining the core measures by which they will be judged. The core measures have been reviewed and some criteria removed. It is hoped that the core measures are not regarded as punitive. The emphasis is on quality, value and cost. Physicians should review the reports carefully and respond to any errors or inaccuracies as soon as possible so the reports can be corrected. In one and a half to two years, the reports will be available to the public so it is important that corrections be made now rather than later.

Adjournment. There being no further business, the meeting adjourned 8:30 p.m.

Attendance. Present were Drs. Sam Hawatmeh, Thomas A. Applewhite, Robert A. Brennan Jr., David L. Pohl, Jay Meyer, Joseph A. Craft III, Elie C. Azrak, Donal A. Blum, Edward L. Burns, J. Collins Corder, Michael Hatlelid, Beverly B. Kraemer, James M. Perschbacher, Janet M. Ruzycki, Michael J. Stadnyk, Stacey S. Tull and Mark D. Wittry. Excused was Dr. Martin Vollmar. Also in attendance were Dr. Laurence Levine, Mr. Thomas Watters and Mrs. Liz Webb.

June 8, 2010

Call to Order. The meeting was called to order by Dr. Sam Hawatmeh at 7:05 p.m. in the conference room at the West County Radiology Office.

Approval of Consent Agenda. The Consent Agenda consisted of May SLMMS Council and SLSMSE Trust minutes and the Membership Report with five new members. Since a quorum was not present, no actions requiring a motion were taken and the consent agenda will be approved in October.

Fall CME Program. The Fall CME Program is scheduled for Wednesday, November 17. A request will be made to have the program at St. John’s Mercy Medical Center. Dr. Elie Azrak, CME Chair, stated the topic will be Health-care Reform and its direct effects on physicians. This will include short- and long-term effects, accountability and the meaning of the bill.

Metropolitan St. Louis Psychiatric Center Closing Update. A letter was written by Dr. Thomas Applewhite to Governor Jay Nixon expressing concerns about the closing of Metropolitan Psychiatric Center (MPC). A response was received from Governor Nixon’s office. A news release was issued, and Dr. Hawatmeh’s letter appeared in the St. Louis Post-Dispatch and was quoted in an article in the St. Louis Beacon.

Acceptance of the Audit. The audit was e-mailed to the Council following the May meeting to give sufficient time for review. The consensus of those in attendance was to accept the audit as presented.

Change in Magazine Publication Dates. Mr. Tom Watters explained that the St. Louis Metropolitan Medicine magazine is published bi-monthly starting with the January/February issue. The publication date is the fifth of the second month (i.e. the January/February magazine is published February 5th). This gives an appearance of lateness to advertisers who may be trying to reach their target audience. The proposed solution is to redate the magazine but leave the publication dates the same. So the first magazine of 2011 will be the February/March issue published February 5th. The proposed change was accepted following discussion.

President’s Report. Dr. Hawatmeh reported on the following items. Dr. Hawatmeh and Mr. Watters attended the BJC staff symposium on April 21 and the Des Peres Hospital staff meeting on May 20 to distribute information and membership applications. The updated list of those members who have not paid their membership dues was distributed. Dr. Hawatmeh thanked those Council members who have approached colleagues to encourage them to pay their membership dues. Dr. Hawatmeh reminded everyone that the focus of the May/June issue of the SLMM magazine is membership. An application is included with each magazine. Members were encouraged to see that copies get into the hands of non-members.

Special Thank You to West County Radiology. Dr. Hawatmeh presented Dr. Applewhite with a plaque thanking him and West County Radiology for hosting the Council meetings at their offices.

Treasurer’s Report. Dr. Pohl gave the Treasurer’s report. The invoices for June totaled $11,451.88, with $6,080 transferred to MSMA for dues, leaving $5,371.88 in miscellaneous bills. There was one SLSMSE invoice for $1,432.10. This was a pass through to MPH for book sale funds collected for Dr. Arthur Gale’s book.

EVP Update. Mr. Watters reported on the following items. The quarterly update from Mason Road Wealth Advisors (MRWA) indicates 32 members are participating in the investment program.

Upcoming Dates. MSMA Council meeting will be July 17-18 in Jefferson City. The Fall CME program will be November 17. The Installation Banquet will be January 15, 2011.

Adjournment. There being no further business, the meeting adjourned 7:35 p.m.

Attendance. Present were Drs. Sam Hawatmeh, Thomas A. Applewhite, Robert McMahon, Robert A. Brennan Jr., David L. Pohl, Jay Meyer, Elie C. Azrak, Thomas A. Davis, Janet M. Ruzycki and Mark D. Wittry. Excused were Drs. Joseph A. Craft III, Donald A. Laird, Mr. Thomas Watters and Mrs. Liz Webb.
Calendar

August 10
SLMMS Executive Committee, 6 p.m.

August 14
Saint Louis University Physician Assistant Annual Updates for Primary Care. Presented by Saint Louis University School of Medicine. CME credits. For more information, call 314-977-7401 or e-mail cme@slu.edu.

August 20-21
20th Annual Conference, “Caring for the Frail Elderly” and the 19th Annual Meeting of the Missouri Association of Long-Term Care Physicians, at the Holiday Inn Select Executive Center, Columbia, Mo. Sponsored in part by University of Missouri School of Medicine. CME credits. Web site http://som.missouri.edu/CME/.

September 6
Labor Day, SLMMS office closed.

September 11
9th Annual Symposium on Gastrointestinal Cancers. Presented by Saint Louis University School of Medicine. CME credits. For more information, call 314-977-7401 or e-mail cme@slu.edu.

September 14
SLMMS Executive Committee, 6 p.m.
SLMMS General Society Meeting on Nominations, 7 p.m.

September 22
“Developing and Operating a Stroke Center: Challenges and Opportunities,” St. Luke's Hospital Institute for Health Education, 5:30-8:00 p.m. at the Emerson Auditorium. Presented by St. Luke's Hospital. CME credits. For more information, call 314-542-4759 or 314-542-4762.

September 30

October 7-9
6th Annual Health Ethics Conference 2010, “Redefining Death in the 21st Century,” at the Reynolds Alumni Center and the Holiday Inn Executive Center, Columbia, Mo. Presented by Center for Health Ethics, University of Missouri School of Medicine. CME credits. For more information, call the CME Office at 573-882-5661 or e-mail carrk@health.missouri.edu. Website http://healthpolicy.missouri.edu.

October 12
SLMMS Council, 7 p.m

October 16-17
MSMA Council, Doubletree Hotel, Jefferson City, Mo.

October 29
8th Annual Missouri Health Policy Summit, at the Garden Conference Center at Hilton Garden Inn, Columbia, Mo. Presented by Center for Health Policy, Office of Continuing Medical Education and MU Sinclair School of Nursing, University of Missouri School of Medicine. For more information, call 573-882-3458, e-mail beckmannli@health.missouri.edu or visit http://healthpolicy.missouri.edu.

November 6-9
AMA Interim Meeting, San Diego, Ca.

November 9
SLMMS Council, 7 p.m.

November 25-26
Thanksgiving, SLMMS office closed.

December 14
SLMMS Council, 7 p.m.

December 23-24
Christmas, SLMMS office closed.

December 30-31
New Year’s 2011, SLMMS office closed.

Health Observances

September

October

List your events: Please send listings of continuing education programs, organizational meetings and other events related to the practice of medicine, to St. Louis Metropolitan Medicine by e-mail editor@slmms.org, by fax to (314) 989-0560, or by mail to Editor, St. Louis Metropolitan Medicine, 680 Craig Rd., Suite 308, St. Louis, MO 63141.
Obituaries

John T. Johnstone Jr., MD

John T. Johnstone, Jr., MD, an internist, died June 3, 2010, at the age of 89. A resident of Webster Groves, Dr. Johnstone spent 45 years specializing in internal medicine and psychosomatic medicine at SSM St. Joseph Hospital of Kirkwood and SSM St. Mary’s Health Center.

He completed his undergraduate studies at Westminster College in Fulton, Mo., and earned his medical degree in 1945 from Washington University School of Medicine. He interned at Touro Infirmary in New Orleans and completed his residency in internal medicine at Missouri Pacific Hospital in St. Louis and his residency in neuropsychiatry at Barnes & McMillan Hospitals.

Dr. Johnstone joined the St. Louis Medical Society in 1952, and published a book review of Gray’s Anatomy 36th British Edition in the Dec. 23, 1981 edition of St. Louis Metropolitan Medicine. He was a Navy veteran and was fluent in Spanish, French and Greek.

The St. Louis Metropolitan Medical Society extends its condolences to Dr. Johnstone’s wife of 62 years, Mary; sons, Mark and Andrew; three grandsons and a nephew. Dr. Johnstone’s funeral was private.

Edwin H. Schmidt, Jr., MD

Edwin H. Schmidt, Jr., MD, a psychiatrist, died June 4, 2010, after a long battle with cancer. He was 86 and a resident of South County.

Dr. Schmidt spent nearly 35 years in private practice in south St. Louis city and county. He was on staff at St. Anthony’s Medical Center, Deaconess Hospital, SSM St. Joseph Hospital of Kirkwood, Lutheran Hospital, SSM St. Mary’s Health Center, Missouri Baptist Medical Center and Saint Louis University Hospital. Dr. Schmidt served as director of Glenwood Psychiatric Hospital, where under his leadership it became the first facility in St. Louis County to integrate black and white psychiatric patients. He was chief of psychiatry, president of the medical staff, and a member of the board of directors at both Deaconess and Lutheran Hospitals. Dr. Schmidt also taught at Saint Louis University, Washington University, and Deaconess Hospital School of Nursing.

He completed his premedical and medical studies at Saint Louis University, graduating from medical school in 1949. Dr. Schmidt interned at Deaconess Hospital and completed a three-year psychiatry residency at Malcolm Bliss Psychopathic Institute. Following his residency, Dr. Schmidt served on active duty in the U.S. Army until his honorable discharge after the Korean War.

Dr. Schmidt joined the St. Louis Medical Society in 1950 and was made a Life Member at his retirement. In 1999, the Missouri State Medical Association awarded him a 50-Year Physician Pin for his service to the medical profession.

Outside of medicine, Dr. Schmidt was an active member of the United Church of Christ and as a member of the church’s Theological Commission, he was instrumental in crafting the UCC Statement of Faith. Dr. Schmidt also served on the board of directors at Eden Seminary for 15 years, including two terms as chairman, one of only two laymen to serve in that capacity in 150 years. Dr. Schmidt also enjoyed traveling and fishing.

The St. Louis Metropolitan Medical Society extends its condolences to Dr. Schmidt’s wife of 63 years, Elizabeth; four sons, Edwin III (MD), Stephen (MD), James, and Martin (MD); 12 grandchildren, Edwin IV, Matthias, Paul (MD), Sarah, Irene, Theodore (MD Class of 2011), Andrew, Elisabeth, Christine, Timothy (MD Class of 2014), Patrick, and Nicholas; and two great-grandchildren. A memorial service for Dr. Schmidt was held at St. Lucas United Church of Christ with interment at Sunset Memorial Park.

Arthur W. Stickle, MD

Arthur W. Stickle, MD, a board-certified ophthalmologist, died July 19, 2010, at the age of 91. He was a resident of Town & Country.

Dr. Stickle developed the former St. Louis Eye Clinics and was an assistant professor of clinical ophthalmology at Washington University School of Medicine. The Arthur W. Stickle Pediatric Ophthalmology Lecture is named for him.

Dr. Stickle obtained his medical degree from the University of Oklahoma in 1943. He was certified in ophthalmology in 1952 and had a subspecialty in ocular motility. He served in the U.S. Navy in 1945 and 1946. He was on staff at St. Luke’s Hospital, SSM DePaul Health Center, Christian Hospital and the former Barnes Hospital, Alexian Brothers Hospital and SSM St. Joseph Hospital-Kirkwood.

He joined the St. Louis Medical Society in 1952 and became a Life Member at his retirement.

The St. Louis Metropolitan Medical Society extends its condolences to Dr. Stickle’s wife of 32 years, Emily; his son Arthur W. III; daughters Marsha Barker, Sandra Martin, Susan Stickle, Karen Wood and Shannon Lemp; 17 grandchildren and 13 great-grandchildren.

A public viewing was held at Bopp Chapel.
SEPTEMBER / OCTOBER BIRTHDAYS

Happy Birthday

SEPTEMBER 1
Subodh Mehra
Steven I. Plax

SEPTEMBER 2
Donald E. Arnold
Sidney Jick
W. Edwin Magee
Kenneth S. Polonsky
Phillip L. Taar
Russell K. L. Won

SEPTEMBER 3
Holly H. Kodner
Charles S. Sherwin

SEPTEMBER 4
Orlando Cruz
Mary A. Tillman

SEPTEMBER 5
Val John Barlow
Salvador Chavez

SEPTEMBER 6
Jeffrey L. Craver
Robert McMahon
Stephen R. Smith
Robert W. Smith

SEPTEMBER 7
Steven Wm. Baak
Jamie Kay Donnelly
Barry I. Feinberg
Laurence J. Kimella
Gary J. Schmidt
Anwar Shah
Ravindra V. Shitut

SEPTEMBER 8
V. Rao Devineni
Jonson E. Flores
Ralph J. Graff
Nancy M. Holekamp
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